

## MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

0439

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge R.F.D.</u> LENGTH OF STAY (in this place) <u>All life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bucktown Rd.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> STREET ADDRESS <u>51 A Douglas Street</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Clarence</u> (Middle) (Last) <u>Ames</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>21</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9-22-1926</u>
9. AGE last birthday <u>24</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Keller, Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Keller, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Chauncey Lee Ames</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Coston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War 2</u>		17. INFORMANT <u>Sally Garrison</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

8225 Immediate cause (a) <u>Intracranial injury</u>	Instant.
1760 Antecedent cause(s) (b) <u>Multiple fractures of skull.</u>	
(c)	

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Injury Highway</u>	(CITY OR TOWN) <u>Nr. Cambridge Md.</u>	(COUNTY) <u>Dor.</u>	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1 21 51 2pm.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Was passenger in auto which overtrned</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-28-51</u>	NAME OF CEMETERY OR CREMATORY <u>Wall Methodist Cemtery</u>	LOCATION (City, town, or county) <u>Cambridge, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1-23-51</u>	REGISTRAR'S SIGNATURE <u>John Mace, Jr., M. D.</u>	24. FUNERAL DIRECTOR <u>Lewis H. Baynuem</u>	ADDRESS <u>Cambridge, Md.</u>	

970VVV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

0440

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u> (near)			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalburg</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>			STREET ADDRESS (If rural, give location) <u>---</u>		
3. NAME OF DECEASED (First) <u>May</u> (Middle) <u>---</u> (Last) <u>Bowdle</u>			4. DATE OF DEATH (Month) <u>1</u> (Day) <u>3</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>5-9-1871</u>		9. AGE last birthday <u>79</u> yrs. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>James Bowdle</u>			14. MOTHER'S MAIDEN NAME <u>Anne White</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY No. <u>---</u>		17. INFORMANT AND ADDRESS <u>Eastern Shore State Hospital records</u>

### 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>443X</u> Cerebral Hemorrhage	(a)	<u>12-28-50</u>
Antecedent cause(s) <u>93d</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	<u>?</u>
	(c) Senile Psychosis with Arteriosclerosis	<u>1942</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-7-, 1950 to 1-3, 1951, that I last saw the deceased alive on 1-2, 1951, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 5, 1950</u>	NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>	LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Jan. 5, 1950</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalburg, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 6 1961  
LIBRARY

Evidence for change of  
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0441

ALM No. G 130 JAN 16 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>21 High Street</u>		STREET ADDRESS (If rural, give location) <u>21 High Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Sarah</u> (First) <u>Wright</u> (Middle) <u>Dail</u> (Last)		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4-30-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>76</u> yrs.
11a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>R. T. Wright</u>		14. MOTHER'S MAIDEN NAME <u>Edith Giles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Calvin Dail, New York, N.Y.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Congestive Heart Failure & Pulmonary Edema

INTERVAL BETWEEN ONSET AND DEATH

24 hours

Antecedent cause(s)

(b) arteriosclerotic Cardiovascular Disease

1 year

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>No</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5-24, 1950, to Jan 7, 1951, that I last saw the deceased

alive on Jan 6, 1951, and that death occurred at 4:48 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Eldridge H. Wolff, M.D.

Cambridge Maryland

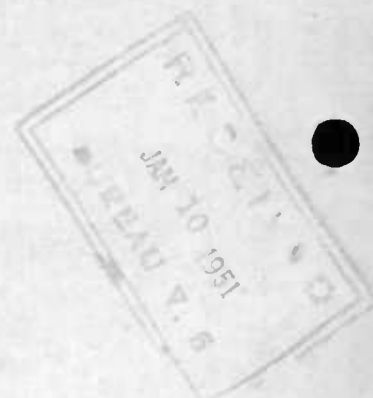
1-8-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-9-51</u>	NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>	LOCATION (City, town, or county) <u>Cambridge, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>1-8-51</u>	REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>	24. FUNERAL DIRECTOR <u>LaCompte Funeral Service, Cambridge, Md</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A151



## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

0442

Reg. Dist. No. 115

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>115 Choptank Ave</u>		STREET ADDRESS (If rural, give location) <u>115 Choptank Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Gray</u> (Middle) <u>Burton</u> (Last) <u>Dean</u>	4. DATE OF DEATH	(Month) <u>Jan</u> (Day) <u>7</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-28-89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Cambridge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Charles A. Dean</u>		14. MOTHER'S MAIDEN NAME <u>Susan K. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes - Military</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Carl Lewis, Choptank Ave, Cambridge</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
4201 Immediate cause (a) <u>Coronary occlusion</u>			<u>5 min</u>
93d Antecedent cause(s) (b) <u>Hypertensive cardiac disease</u>			<u>?</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>John Mace, M.D.</u>		ADDRESS <u>Cambridge Md.</u>	
DATE SIGNED <u>1/3/51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan 4-1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenlawn</u>		LOCATION (City, town, or county) <u>Cambridge Md</u>	
DATE REC'D BY LOCAL REG. <u>Jan 3, 1951</u>		REGISTRAR'S SIGNATURE <u>John Mace, J. N. D.</u>	
24. FUNERAL DIRECTOR <u>Samuel R. Thomas</u>		ADDRESS <u>Cambridge</u>	

910126 md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







## MARYLAND STATE DEPARTMENT OF HEALTH

0443

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>330 Washington Street</b>		STREET ADDRESS (If rural, give location) <b>330 Washington Street</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>SALLIE</b>	(Middle) <b>MOIRA TYLER</b>	(Last) <b>HENRY</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11/4/1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE last birthday <b>70</b> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jackson Tyler</b>		14. MOTHER'S MAIDEN NAME <b>Todd</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Lee Henry, (See NO # 2)</b>			

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**Cerebral hemorrhage**

INTERVAL BETWEEN ONSET AND DEATH

**20 Min.****331X Immediate cause****Antecedent cause(s)****83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last**11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing in the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Deputy Medical Examiner Dorchester county.****1/4/51**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>1/7/1951</b>	<b>Greenlawn Cemetery</b>	<b>Cambridge, Maryland</b>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>Jan. 5, 1951</b>	<b>John Mace, Jr., M.D.</b>	<b>LeCompte Funeral Service</b>		

**Cambridge, Maryland**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

0444

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Delaware</u> COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington St E/17</u>		STREET ADDRESS <u>R. 7-D 5</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First)	<u>Frank</u> (Middle)	<u>Hudson</u> (Last)	4. DATE OF DEATH <u>Jan 15</u> 19 <u>51</u> (Month) (Day) (Year)
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-15-1923</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harmon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	9. AGE last birthday <u>27</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Georgetown Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles W. Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Stella C. Donovan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Lloyd W. Hudson Georgetown</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Suffocation

INTERVAL BETWEEN ONSET AND DEATH

Instant

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, OF office bldg, etc.) INJURY <u>Saw mill</u>	(CITY OR TOWN) <u>Cambridge</u>	(COUNTY) <u>Dor.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan 15 51 11a</u>	INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Pile of saw dust caved in on him.</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John Mace Jr M.D.  
 Deputy Medical Examiner

Cambridge, Md.

1/16/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	DATE THEREOF <u>Jan 18, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mechanics Cemetery</u>	LOCATION (City, town, or county) <u>Wellsboro</u>	(State) <u>Del.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 16/51</u>	REGISTRAR'S SIGNATURE <u>John Mace Jr</u>	24. FUNERAL DIRECTOR <u>Ronald James</u>	ADDRESS <u>Wellsboro Del</u>	
		<u>Kenneth R. Thomas Cambridge Del</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

0445

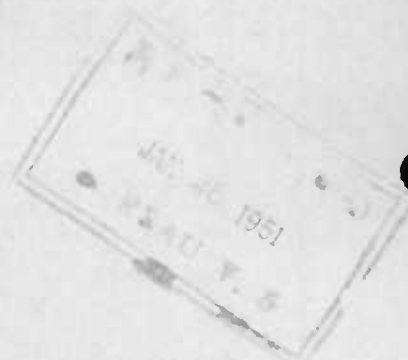
Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Roslyn Avenue</b>		STREET ADDRESS (If rural, give location) <b>Roslyn Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>JOHN</b> (First) <b>K.</b> (Middle) <b>HURLEY</b> (Last)	4. DATE OF DEATH <b>JAN</b> (Month) <b>23</b> (Day) <b>51</b> (Year)		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>5/22/1904</b>
9. AGE last birthday <b>46</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John L. Hurley</b>		14. MOTHER'S MAIDEN NAME <b>Minnie C. Orem</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY No. <b>not known</b>	
17. INFORMANT <b>Viola R. Hurley, Cambridge, Md.</b>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <b>Cerebral Hemorrhage</b>			<b>5 min</b>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>None</b>			
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Yes</b>			
19a. DATE OF OPERATION <b>None</b>		19b. MAJOR FINDINGS OF OPERATION <b>None</b>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <b>None</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>None</b> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>Edridge H. Wolff MD</b>		DATE SIGNED <b>1-24-51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>1/26/1951</b>	
NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
DATE REC'D BY LOCAL REG. <b>1-25-51</b>		24. FUNERAL DIRECTOR <b>LeCompte Funeral Service</b>	

970246 Cambridge, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0446 116

1. PLACE OF DEATH- COUNTY <b>Dorchester</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cambridge</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Appleby Avenue</b>		MARYLAND LENGTH OF STAY (in this place) <b>19 months</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Dorchester</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cambridge</b> STREET ADDRESS (If rural, give location) <b>Appleby Avenue</b>	
3. NAME OF DECEASED (Type or Print) <b>Walter</b> (First) <b>Thomas</b> (Middle) <b>Insley</b> (Last)		4. DATE OF DEATH (Month) <b>January</b> (Day) <b>31</b> (Year) <b>51</b> 19			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 7, 1879</b>	9. AGE last birthday <b>71</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N.J. State Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Elijah Insley</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Ellis</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT AND ADDRESS <b>Mrs. Mildred R. Bramble, Rhodesdale, Md.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **CORONARY THROMBOSIS**

INTERVAL BETWEEN ONSET AND DEATH

**5 MIN.**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**DIABETES MELLITUS**

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **1 Oct**, 19**49**, to **31 JAN**, 19**51**, that I last saw the deceasedalive on **30 JAN**, 19**51**, and that death occurred at **5:45 P.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Feb. 3, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Eldorado Cemetery</b>	LOCATION (City, town, or county) <b>Eldorado, Maryland</b>	(State)
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DATE REC'D BY LOCAL REG. <b>February 3, 1951</b>	REGISTRAR'S SIGNATURE <b>John M. J. M.D.</b>	24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Md.</b>	ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

730869



RECEIVED  
FEB 8 1961  
BIRMINGHAM A. B.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

0447

Reg. Dist. No. 1-1-0

1. PLACE OF DEATH- COUNTY <u>Corrothers</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>007</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Williamstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Williamstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frances</u> (Middle) <u>Marie Cephon</u> (Last) <u>Jackson</u>	4. DATE OF DEATH	(Month) <u>Jan</u> (Day) <u>17</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 21, 1915</u>
9. AGE last birthday <u>35</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Harlem, N.Y.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>John Cephon</u>	14. MOTHER'S MAIDEN NAME <u>Mary Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>214-28-3173</u>	17. INFORMANT <u>Mary Ross Cephon</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary occlusion  
 Antecedent cause(s) (b) 94a  
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH 8 hrs

II. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 19, 1951

Chas W Hastings

J. J. Trumpton and Son, Federalburg, Maryland

970609

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Rural - Hurlock</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>Life</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hurlock</u> TOWN <u>Rural - Hurlock</u> STREET ADDRESS (If rural, give location) <u>Cabin Creek</u>	
3. NAME OF DECEASED (Type or Print) <u>Fred</u>		(First) (Middle) (Last) <u>Jews</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 2 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>September 22, 1879</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Horace Jews</u>			14. MOTHER'S MAIDEN NAME <u>Martina Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Catherine Elbert - Hurlock, Md. R 7 D.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary thrombosisAntecedent cause(s) (b) General arteriosclerosis94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) auricular fibrillation

INTERVAL BETWEEN ONSET AND DEATH

1 week

5 yrs +

1 week.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 27, 1950, to Jan. 2, 1951, that I last saw the deceasedalive on Dec. 27, 1950, and that death occurred at 8:00 A.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. E. Harrison MDHurlock, Md.1/6/51BurialJan 6 - 1951Washington (Colored)Near Hurlock(State)Jan 6 - 1951Charles HastingsJ. J. Frampton & SonFederal House Md

820105



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u> (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Perryville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural, give location) <u>--</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sarah</u> (Middle) <u>--</u> (Last) <u>McCann</u>	4. DATE OF DEATH	(Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>7-15-1883</u>
9. AGE last birthday <u>67</u> yrs.		10. If under 1 year Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Millard Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Louise Singleton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No. <u>--</u>	
17. INFORMANT AND ADDRESS <u>Eastern Shore State Hospital records</u>			

### 18. MEDICAL CERTIFICATION

#### 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Edema of the Lungs

#### INTERVAL BETWEEN ONSET AND DEATH

12-27-50

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Bronchitis, emphysema, Hypertensive Cardio-Vascular Disease

1940

(c) Psychosis with Convulsive Disorders

1929

#### 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-7-, 1950, to 1-4, 1951, that I last saw the deceased

alive on 1-4, 1951, and that death occurred at 7:03 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ethel B. Herrmann Green MD. Eastern Shore State Hospital, Camb., Md. 1-4-51

#### 23. BURIAL, CREMATION REMOVAL (Specify)

#### DATE TIME OF

#### NAME OF CEMETERY OR CREMATORY

#### LOCATION (City, town, or county)

#### (State)

DATE REC'D BY LOCAL REG. Jan. 5, 1951

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

John Mace, Jr. M.D. Lee A. Patterson & Son Perryville Maryland.

720826

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1961  
JAN 8 1961  
RECEIVED  
U.S. AIR FORCE



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0450

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Andrews</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Andrews</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS (none)		STREET ADDRESS (none)	
3. NAME OF DECEASED (Type or Print)	(First) <u>IDA</u>	(Middle) <u>WROTEN</u>	(Last) <u>MOORE</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>unknown</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT AND ADDRESS <u>Mrs. John Jones, Andrews, Md.</u>

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Myocardial Failure</u>			<u>2 days</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Bronchopneumonia</u>			<u>2 weeks</u>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Peritonal Rt Hemiplegia</u>			<u>12 yrs</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/17</u> , 19 <u>50</u> , to <u>1/20</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>51</u> , and that death occurred at <u>1/20</u> , 19 <u>51</u> , from the causes and on the date stated above.			
SIGNATURE <u>John M. Jones</u>		ADDRESS <u>Cambridge Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/22/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Family burial lot</u>	LOCATION (City, town, or county) (State) <u>Andrews, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Jan, 22, 1951</u>	REGISTRAR'S SIGNATURE <u>John M. Jones M.D.</u>	24. FUNERAL DIRECTOR <u>LeCompte Funeral Service,</u> <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

RECEIVED  
JUN 26 1951  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

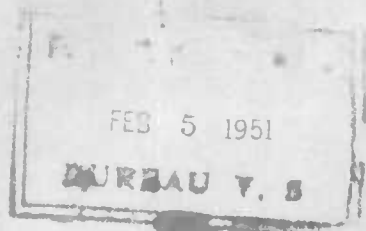
## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

0451

Reg. Dist. No. 110

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hurlock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #1</u>		STREET ADDRESS (If rural, give location) <u>RFD #1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Howard</u> (Middle) <u>Perkins</u> (Last) <u>Perkins</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/17/1884</u>
9. AGE last birthday <u>66</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>	
12. FATHER'S NAME <u>Unknown</u>		13. MOTHER'S MAIDEN NAME <u>Unknown</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		15. SOCIAL SECURITY NO. <u>none</u>	
16. INFORMANT <u>Roxie Perkins Daughter</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>			<u>15 min.</u>
Antecedent cause(s) (b) <u>Arterio Sclerotic Cardio-Vascular Disease</u>			<u>7</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		(STATE)	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title)		ADDRESS	
<u>Eldridge H. Wolff MD</u>		<u>Cambridge</u>	
DATE SIGNED			
<u>1-29-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Hurlock Col Cemetery</u>	
DATE THEREOF <u>Jan 31 1951</u>		LOCATION (City, town, or county) (State)	
<u>Hurlock</u>		<u>MD</u>	
DATE REC'D BY LOCAL REG		24. FUNERAL DIRECTOR ADDRESS	
<u>Jan 31-1951</u>		<u>Chas H Hastings</u>	
<u>Chas H Hastings</u>		<u>416 Kilbuck Hwy Hurlock</u>	
<u>970116</u>		<u>md</u>	



FEB 5 1951

BUREAU T. S.

0452

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH- COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Vienna</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Vienna</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <b>Rufus</b> (Middle) <b>A.</b> (Last) <b>Pinkett</b>		4. DATE OF DEATH (Month) <b>January</b> (Day) <b>17</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 15, 1891</b>
9. AGE last birthday <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.) <b>Fireman - Stationary Boiler Canning Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Pinkett</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Blake</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>217-05-7931</b>	
17. INFORMANT AND ADDRESS <b>Ethel B. Pinkett, Vienna, Maryland</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 Immediate cause (a) **Chronic Myocardial Degeneration**

93d Antecedent cause(s) (b) **General arteriosclerosis**

(c)

INTERVAL BETWEEN ONSET AND DEATH

**5 yrs +**

**5 yrs +**

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 1945, to Jan., 1951, that I last saw the deceased alive on Jan. 7, 1951, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Jan. 21, 1951</b>	NAME OF CEMETERY OR CREMATORY <b>Vienna Col. Cemetery</b>	LOCATION (City, town, or county) <b>Vienna, Maryland</b>	(State)
DATE REC'D BY LOCAL REG <b>Jan 21 - 51</b>	REGISTRAR'S SIGNATURE <b>Elizabeth H. Brady</b>	24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalburg, Md.</b>	ADDRESS	

680408

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
JUN 23 1951  
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

0453

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Dor.</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cambridge</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Market St.</b>		STREET ADDRESS (If rural, give location) <b>Washington St.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Lateeny</b> (Middle) (Last) <b>Rideout</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>January 10 1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>July 5, 1888</b> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Oyster shucker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oysterhouse</b>	9. AGE last birthday <b>62</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>George W. Harris</b>		14. MOTHER'S MAIDEN NAME <b>Willie M. Hughes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Chelsea Caldwell</b>		<b>Cambridge Md. #1</b>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

(a) **Immediate cause** **Coronary occlusion** 10 Min.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS  
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title)

ADDRESS

DATE SIGNED

**John Mace, Jr. M.D.** **Cambridge, Md.**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **1-23-51** NAME OF CEMETERY OR CREMATORY **Bethel Cemetery** LOCATION (City, town, or county) (State) **Cambridge, Maryland**

DATE RECD. BY LOCAL REGISTRAR'S SIGNATURE **John Mace, Jr., M. D.** 24. FUNERAL DIRECTOR **Lewis H. Bayneum** ADDRESS **Cambridge, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

790 408





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. .... 116

1. PLACE OF DEATH- COUNTY <b>Dorchester</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cambridge</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>100 Glasgow Street</b>				STREET ADDRESS (If rural, give location) <b>100 Glasgow Street</b>	
3. NAME OF DECEASED (Type or Print) <b>SARAH</b>		(Middle) <b>WINGATE</b>		(Last) <b>SEWELL</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	
8. DATE OF BIRTH <b>3/14/1869</b>		9. AGE last birthday <b>82 yrs.</b>		4. DATE OF DEATH (Month) <b>JAN</b> (Day) <b>20</b> (Year) <b>1951</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas H. Wingate</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hall</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>none</b>		17. INFORMANT AND ADDRESS <b>Mrs. Daisey Sewell, Cambridge, Md.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>Coronary Thrombosis</b>		<b>Sudden</b>	
Antecedent cause(s) (b) <b>Arteriosclerosis Generalized</b>		<b>10 years</b>	
(c) <b>Myocarditis Chronic</b>		<b>5 years</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1948, to Dec, 1951, that I last saw the deceased alive on 20th Dec 51, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE Hugh Brown ADDRESS Cambridge DATE SIGNED Dec 21/51

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>1/22/1951</b>		NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		LOCATION (City, town, or county) <b>Cambridge, Maryland</b>		(State)	
DATE REC'D BY LOCAL REG. <b>Jan. 22, 1951</b>		REGISTRAR'S SIGNATURE <u>John Drace Jr. M.D.</u>		24. FUNERAL DIRECTOR <b>LeCompte Funeral Service,</b>		ADDRESS			

Cambridge, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

0455

## CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <i>Dorchester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Dorchester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>Cambridge</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>Cambridge Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>113 miur st</i>		STREET ADDRESS (If rural, give location) <i>113 miur st</i>	
3. NAME OF DECEASED (Type or Print) <i>Samuel Columbus</i> (First) <i>Short</i> (Last)		4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>8</i> (Year) <i>1951</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>1863</i>
9. AGE last birthday <i>87</i> yrs.		10. If under 1 year: Months <i>7</i> Days <i>19</i> Hours <i>51</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Armed Forces</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Short</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mooney</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Daughter (Maud Sanders)</i>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <i>Cerebral Apoplexy</i>		<i>2 days</i>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Arteriosclerosis Generalized</i>		<i>7 yrs</i>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <i>Hugh Brown</i>	DATE THEREOF <i>Jan 11, 1951</i>	NAME OF CEMETERY OR CREMATORY <i>East New Market</i>	LOCATION (City, town, or county) <i>East New Market</i>	DATE SIGNED <i>Jan 8, 1951</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	24. FUNERAL DIRECTOR <i>J. H. Halloughley</i>	ADDRESS <i>100105</i>		
DATE REC'D BY LOCAL REG. <i>1-10-51</i>	REGISTRAR'S SIGNATURE <i>John M. Jr. M.D.</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

0456

Reg. Dist. No. .... 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dor</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
TOWN <u>306 Maryland Ave</u>		TOWN <u>306 Maryland Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Milton</u> <u>Sullivan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 23</u> 19 <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>July 13-1861</u>
9. AGE last birthday <u>89</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Emily Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>now</u>	
17. INFORMANT <u>Mrs Ida Sullivan</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Uremia</u>		<u>3 days</u>
Antecedent cause(s) (b) <u>Fracture neck left femur.</u>		<u>2 weeks</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office hldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>3</u> <u>51</u> <u>7</u> a.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Slipped and fell to floor</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>John Mace Jr.</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Cambridge Md.</u>	DATE SIGNED <u>1/27/51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 26-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cambridge</u>	LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>
DATE REC'D BY LOCAL REG. <u>1-25-51</u>	REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>	24. FUNERAL DIRECTOR <u>Reverth R. Thomas</u>	ADDRESS <u>Cambridge Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 20 1951  
U.S. AIR FORCE  
OFFICE OF THE  
JUDGE ADVOCATE GENERAL



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Hudson</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Hudson</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>(none)</b>		STREET ADDRESS <b>(none)</b> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <b>CLARA</b> (Middle) <b>FIGGS</b> (Last) <b>THOMAS</b>		4. DATE OF DEATH (Month) <b>JAN</b> (Day) <b>12</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>10/13/1874</b>
9. AGE last birthday <b>76</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James B. Figgs</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Wheeler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT AND ADDRESS <b>Everett Thomas, Easton, Maryland</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Bronchogenic carcinoma</b>	<b>8 months</b>	
Antecedent cause(s) (b) <b>Carcinoma of urinary bladder</b>	<b>8 months</b>	
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <b>INJURY</b>
(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5/30, 1950**, to **Jan 13, 1951**, that I last saw the deceased alive on **Jan 9, 1951**, and that death occurred at **11:30 a.m.**, from the causes and on the date stated above.

SIGNATURE **Laurence Harganov M.D.** ADDRESS **Cambridge, Md.** DATE SIGNED **1/15/51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>1/16/1951</b>	NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park, Cambridge, Maryland</b>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <b>1-16-51</b>	REGISTRAR'S SIGNATURE <b>John Mace, Jr. - M.D.</b>	24. FUNERAL DIRECTOR <b>LeCompte Funeral Service,</b>	ADDRESS <b>Cambridge, Maryland</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 19 1951

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 111

0458

1. PLACE OF DEATH- COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>East New Market - Rural</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>East New Market - Rural</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Thompstontown</b>		STREET ADDRESS (If rural, give location) <b>Thompstontown</b>	
3. NAME OF DECEASED (First) <b>William</b> (Middle) <b>W.</b> (Last) <b>Thompson</b>		4. DATE OF DEATH (Month) <b>January</b> (Day) <b>19</b> (Year) <b>1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 18, 1896</b>
9. AGE last birthday <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. C. Thompson</b>		14. MOTHER'S MAIDEN NAME <b>Susan A. Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Hattie S. Thompson, East New Market, Md.</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.0 Immediate cause (a) <b>Cerebral hemorrhage</b>		<b>4 days</b>
93d Antecedent cause(s) (b) <b>Arteriosclerotic Heart Disease</b>		<b>Unknown</b>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) <b>SUICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

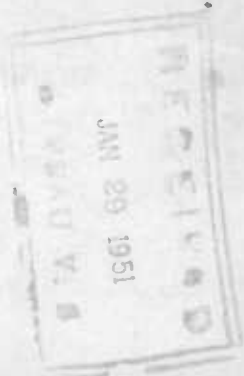
22. I hereby certify that I attended the deceased from <b>12/31</b> , 19 <b>50</b> , to <b>1/19</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>1/15</b> , 19 <b>51</b> , and that death occurred at <b>9:45</b> p.m., from the causes and on the date stated above.	
SIGNATURE <b>Laurence Maryanov M.D</b>	DATE SIGNED <b>1/20/51</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	NAME OF CEMETERY OR CREMATORY <b>Thompstontown Cemetery</b>
DATE REC'D BY LOCAL REG. <b>1/21/51</b>	24. FUNERAL DIRECTOR <b>J.J. Frampton and Son, Federalsburg, Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105



0459

Evidence for change  
in age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

FILM No. G 130 FEB 14 1951

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>30 Skinner's Court</u>		STREET ADDRESS (If rural, give location) <u>Skinner's Court 30</u>	
3. NAME OF DECEASED (Type or Print) <u>Oliver Thompson</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. <del>WIDOWED</del> <u>WIDOWED</u> (Specify)	8. DATE OF BIRTH <u>March 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. FATHER'S NAME <u>William Thompson</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. SOCIAL SECURITY No. <u>none</u>		16. INFORMANT AND ADDRESS <u>Francis Thompson</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

434.1 Immediate cause (a) Chronic Stomach  
Antecedent cause(s) (b) Chronic Stomach  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

#### II. OTHER SIGNIFICANT CONDITIONS

\* Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1-28-51, 1951, to 1-30, 1951, that I last saw the deceased alive on 1-30, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>2-4-51</u>	<u>Taylor's Island Cemetery</u>	<u>Taylor's Island</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2-4-51</u>	<u>John Mace Jr. M.D.</u>	<u>Louis H. Bayne</u>	<u>Cambridge Md.</u>	

523408

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

0460

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 111

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>East New Market</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>East New Market</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Jeremiah Fletcher Varnes</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11/17/51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2/28/1891</u>
9. AGE last birthday <u>59</u> yrs.		10. UNDER 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Invalid)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Varnes</u>		14. MOTHER'S MAIDEN NAME <u>Mary McAllister</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Sallie Varnes (Sister)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>Coronary occlusion</u>		<u>5 Min.</u>
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE John M. Moore (Degree or title) M.D. ADDRESS Cambridge, Md. DATE SIGNED 11/18/51

Deputy Medical Examiner

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>11/20/51</u>	<u>East New Market</u>	<u>East New Market, Dor. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>11/19/51</u>	<u>Elizabeth C Smith</u>	<u>J.B. Willoughby</u>	<u>East New Market, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JAN 29 1951  
BUREAU 7.8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hospital</u>		STREET ADDRESS (If rural, give location) <u>222 Cedar St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Curtis</u> (Middle) <u>Whitlock</u> (Last) <u>Whitlock</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Sept. 1, 1901</u> 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday (If under 1 year Months Days) (If under 24 hrs. Hours Min.)
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Plummer Whitlock</u>		14. MOTHER'S MAIDEN NAME <u>Marty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Richard Whitlock - Potomac Virginia</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241x Immediate cause (a) Myocardial FailureAntecedent cause(s) (b) Bronchial Asthma

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

Week  
?

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 5, 1951 to Jan. 12, 1951, that I last saw the deceased alive on 1/12/51, 1951, and that death occurred at 5.05a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-17-51</u>	NAME OF CEMETERY OR CREMATORY <u>Dorchester</u>	LOCATION (City, town, or county) <u>Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan. 16/51</u>	REGISTRAR'S SIGNATURE <u>John M. [Signature]</u>	24. FUNERAL DIRECTOR <u>Lewis A. Henry</u>	ADDRESS <u>Cambridge Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

0462

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9 Cedar Street</u>		STREET ADDRESS (If rural, give location) <u>9 Cedar Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>DELIA</u>	(Middle) <u>ABBOTT</u>	(Last) <u>WILLEY</u>
6. SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	4. DATE OF DEATH JAN 15 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	8. DATE OF BIRTH 3/16/1873
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		9. AGE last birthday <u>77</u> yrs.	
13. FATHER'S NAME <u>William Abbott</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Not Known</u>		11. INFORMANT AND ADDRESS <u>9 Cedar Street</u> <u>Frank Willey-- Cambridge, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>420.0</u>	<u>Coronary occlusion</u>	<u>2 wks.</u>
Antecedent cause(s) (b) <u>93d</u>	<u>Arteriosclerotic Heart Disease</u>	<u>unknown</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Dec 30, 1950</u> , to <u>Jan 15, 1951</u> ; that I last saw the deceased alive on <u>Jan 15, 1951</u> , and that death occurred at <u>10:57</u> m., from the causes and on the date stated above.	
SIGNATURE <u>Lawrence Maryanor M.D.</u>	DATE SIGNED <u>1/18/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/18/51</u>
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service,</u>	ADDRESS <u>Cambridge, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Jan. 18, 1951</u>	REGISTRAR'S SIGNATURE <u>John Mace Jr. MD</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

0463

1. PLACE OF DEATH- COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bucktown</u> TOWN <u>Bucktown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(none)</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bucktown</u> TOWN <u>Bucktown</u> STREET ADDRESS <u>(none)</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>EDITH</u> (First) <u>LOWE</u> (Middle) <u>WILEY</u> (Last)		4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>7/14/1876</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Travers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. Mace Willey, Cambridge, Md.</u>		RFD # <u>2</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardiovascular-renal disease

INTERVAL BETWEEN ONSET AND DEATH

5 years

Antecedent cause(s)

(b)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7 APRIL, 1949, to 12 JAN, 1951, that I last saw the deceased alive on 12 JAN, 1951, and that death occurred at 4 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE TIME OF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/14/1951</u>	<u>Dorchester Memorial Park</u>	<u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Jan. 14. '51</u>	<u>John Mace Jr. M.D.</u>	<u>LeCompte Funeral Service,</u> <u>Cambridge, Maryland</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15





## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0464

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>RED # 50</b>		STREET ADDRESS (If rural, give location) <b>RED # 50</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>EDWARD</b>	(Middle) <b>R.</b>	(Last) <b>WILLIAMS</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12/2/1882</b>
9. AGE last birthday <b>68 yrs.</b>		4. DATE OF DEATH (Month) <b>JAN</b> (Day) <b>3</b> (Year) <b>1951</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fishing Indust.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reed Williams</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT AND ADDRESS <b>Herman J. Paul, Cambridge, Maryland</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4221 Immediate cause

(a) **Chronic Myocarditis**

93d Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Arterio Sclerosis - generalised**

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 yrs

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Dec 21, 1950**, to **Jan 3, 1951**, that I last saw the deceasedalive on **Jan 2, 1951**, and that death occurred at **6:40 p.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>1/5/1951</b>	<b>Dorchester Memorial Park</b>	<b>Cambridge, Maryland</b>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<b>Jan 5, 1951</b>	<b>John Mac, Jr., D.D.</b>	<b>LeCompte Funeral Service,</b>	<b>Cambridge, Maryland</b>	

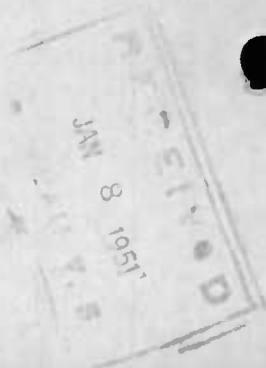
910126

Cambridge, Maryland

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

0465

Reg. Dist. No. 116

1. PLACE OF DEATH- COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge-Maryland Hospital</b>		STREET ADDRESS (If rural, give location) <b>225 High Street</b>	
3. NAME OF DECEASED (First) <b>Hattie</b> (Middle) <b>May</b> (Last) <b>Woolford</b>		4. DATE OF DEATH (Month) <b>1</b> (Day) <b>30</b> (Year) <b>1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6-4-1880</b>
9. AGE last birthday <b>70</b> yrs.		10. If under 1 year Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>maid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Tamer Farrare</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>220-26-1322</b>	
17. INFORMANT <b>Sarah F. Wallace, Cambridge, Maryland</b>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <b>Immediate cause</b> <b>Laceration and Contusion of Brain</b>		<b>8 hours</b>
(b) <b>Antecedent cause(s)</b> <b>Fracture of Skull</b>		<b>8 hours</b>
(c) <b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</b>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>renal disease. Hypertensive arteriosclerotic cardio vascular</b>		?
19a. DATE OF OPERATION <b>none</b>	19b. MAJOR FINDINGS OF OPERATION <b>-- --</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>street</b>	(CITY OR TOWN) <b>Cambridge</b> (COUNTY) <b>Dorchester</b> (STATE) <b>Maryland</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>1 30 1951 12:20 p.m.</b>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <b>Deceased was pedestrian struck by car.</b>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

*Eldridge H. Wallace*

Assistant Deputy

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>2-4-51</b>	NAME OF CEMETERY OR CREMATORY <b>Waugh Cemetery</b>	LOCATION (City, town, or county) <b>Cambridge, Maryland</b>	(State) <b>Maryland</b>
DATE REC'D BY LOCAL REG. <b>2-2-51</b>	REGISTRAR'S SIGNATURE <i>John Mace Jr. M.D.</i>	24. FUNERAL DIRECTOR <b>Herbert M. StClair, Jr., Cambridge, Md.</b>	ADDRESS	

731658

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

